

INSTRUCTIONS FOR COMPLETING FORM

PLEASE NOTE: A SEPARATE ADJUSTMENT/VOID REQUEST FORM MUST BE COMPLETED AND SUBMITTED FOR EACH CLAIM LINE YOU WOULD LIKE TO ADJUST OR VOID.

- I. Provider Information
 - a. Provider name: Enter name of provider.
 - b. Street Address: Enter the street address of the facility.
 - c. City, State, Zip: Enter the City, and Zip Code of the facility.
 - d. Provider Number: Enter your 7-digit provider number.
- II. Indicated by checking the appropriate box whether the request relates to:
 - a. Underpayment
 - b. Overpayment where a refund check for the amount of overpayment is attached.
 - c. Overpayment where you wish the amount of overpayment to be deducted from future claim payments.
- III. Give Reason for Adjustment Request: Give the specific reason for your request for an adjustment.
- IV. TPL Information: If AV Request is due to third party payment, complete items (a.) through (d.) or attach a copy of the check received from the insurance company.
- V. Refer to your Remittance Advice for the following data. Enter all data requested.
 - a. Claim Number: Enter the 13-digit claim number found on the R/A.
 - b. Patient Name: Enter the patient's last name, first name, and middle initial.
 - c. Recipient ID Number: Enter the 11-digit recipient identification number exactly as it is found on the R/A.
 - d. Remittance Advice Date: Enter the date of the Remittance Advice found at the top right corner of the R/A.
 - e. Date of Service: Enter the date of service.
 - f. Billed Amount: Enter the amount actually billed.
 - g. Monthly Patient Liability: Enter the complete liability amount shown on the 2362 and the effective date (ICF/SNF use only).
- VI. Signature: Signature of the requestor and the date the request was prepared.

I hereby certify that the claim for services listed on the reverse of this form is true and correct; that the amount is due; that the amount received (as determined by the Single State Agency within limits defined by State and Federal laws) will be accepted as full payment for all services rendered the patient as set forth hereon; that no unlisted payment is due or has been received; and that no third party payments will be accepted in excess of the determined usual and customary charges for services rendered or directed by the physician/practitioner; that the physician/practitioner is licensed to practice under the laws of the State of Tennessee or other state in which services were rendered; that pertinent medical information will be made available to authorized representatives of the State Agency subject to appropriate legal, ethical and professional limitations; and that this claim for payment under Medicaid-Title XIX Program is for services rendered to a properly identified eligible recipient. I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under the States Title XIX plan and to furnish information regarding any payments claimed for providing such services as the State Agency may request for three years from date of service. The State Agency operates under the provisions of Title VI of the Civil Rights Act of 1964 and Section 504 of the Rehabilitation Act of 1973. Under the provisions of these Acts any provider of services receiving Federal funds must comply with the intent of these Acts, and this means there shall be no discrimination because of race, color, national origin or handicap. These Acts also provide for strict compliance and complaint procedures. I understand that payment and satisfaction of this claim will be Federal and State funds and that any false claim, statements, or documents, or concealment of a material fact may be prosecuted under applicable Federal and State laws.